

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 010888	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2012
NAME OF PROVIDER OR SUPPLIER STERLING HOUSE OF RICHMOND			STREET ADDRESS, CITY, STATE, ZIP CODE 3700 S A ST RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00104735.</p> <p>Complaint IN00104735-Unsubstantiated due to lack of evidence.</p> <p>Survey date: March 14, 2012</p> <p>Facility number: 010888 Provider number: 010888 AIM number: N/A</p> <p>Survey team: Barbara Gray RN TC Angel Tomlinson RN</p> <p>Census bed type: Residential: 39 Total: 39</p> <p>Census Payor type: Other: 39 Total: 39</p> <p>Sample: 3</p> <p>Sterling House of Richmond was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00104735.</p> <p>Quality review completed 3/15/12 by Jennie Bartelt, RN.</p>	R 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

6SG911

If continuation sheet 1 of 1